

**IN ACCORDANCE WITH TASC 3 PROCEDURES AND DUE TO TIME
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PROPOSALS (RFTOP) THAT WILL BE ISSUED ONCE FUNDS BECOME
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Malaria prevention and control activities in Mozambique

INTRODUCTION

In July 2005, the United States Government announced a new five-year, \$1.2 billion initiative to rapidly scale up malaria prevention and treatment interventions in high-burden countries in sub-Saharan Africa. The goal of the President's Malaria Initiative (PMI) is to reduce malaria-related mortality by 50% after three years of full implementation. This will be achieved by reaching 85% coverage of the most vulnerable groups---children under five years of age and pregnant women---with proven preventive and therapeutic interventions, including artemisinin-based combination therapies (ACTs), insecticide-treated nets (ITNs), intermittent preventive treatment of pregnant women (IPTp), and indoor residual spraying (IRS). Mozambique is one of 15 countries included in the PMI.

BACKGROUND

Malaria in Mozambique accounts for about six million reported cases per year, 44% of all outpatient consultations, and 65% of all pediatric hospital admissions. The estimated malaria prevalence among children 2-9 years of age in Mozambique ranges from 40% to 80%. Malaria is reported by the Ministry of Health (MoH) to be the primary cause of death among children admitted to pediatric services in Mozambique (32% in 1998, 42% in 1999 and 40% in year 2000). Approximately 20% of pregnant women in rural areas are infected with malaria parasites and, among primigravidae (first pregnancies) this figure can reach 30%. Anemia due to malaria is a major cause of morbidity and mortality in children and pregnant women and malaria is a leading cause of low birth weight in the newborn.

Although the World Health Organization reports that 100% of Mozambique's population of 19.4 million is at risk of malaria, it is unlikely that there is malaria transmission in central urbanized areas of the capital, Maputo, where approximately 1 million (5% of the population) people reside. Thus, for the purposes of establishing targets for the PMI in Mozambique, it will be assumed that 95% of the population (or 18 million people) are at risk of malaria.

According to the most recent Demographic and Health (DHS) survey, carried out between September and December 2003, 18% of women between 15 and 49 years of age had a bed net, but only 12% of pregnant women and 10% of children under five had slept under an ITN the previous night. A survey in Manica and Sofala Provinces following the large measles-ITN distribution campaign in November 2005 showed >90% usage rates among residents who had a bed net. Indoor residual spraying supported by the MoH and the Lubombo Spatial Development Initiative covers parts of 46 districts, but the proportion of households covered is not known. No up-to-date information exists on national or provincial coverage with ACTs or IPTp.

The goal of the PMI is to reduce malaria-related mortality by 50% compared to pre-Initiative levels by 2010. The following targets will be reached for populations at risk of malaria in Mozambique:

1. More than 90% of households with a pregnant woman and/or a child under five (in areas not covered by IRS) will own at least one ITN;
2. 85% of children under five (in areas not covered by IRS) will have slept under an ITN the previous night;

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3. 85% of pregnant women (in areas not covered by IRS) will have slept under an ITN the previous night;
4. 85% of houses in geographic areas targeted for IRS will have been sprayed;
5. 85% of pregnant women and children under five will have slept under an ITN or in a house that has been sprayed with a residual insecticide within three months before the last transmission season;
6. 85% of pregnant women who have completed a pregnancy in the last two years will have received two or more doses of SP for IPTp during that pregnancy;
7. 85% of government health facilities will have ACTs available for the treatment of uncomplicated malaria; and
8. 85% of children under five with suspected malaria will have received treatment with an antimalarial drug in accordance with national malaria treatment policies within 24 hours of the onset of their symptoms.

1. STATEMENT OF WORK

This request for task order proposal (RFTOP) is intended to focus on the following objectives in collaboration with the MoH and under the guidance of the National Malaria Control Program (NMCP), and is contingent on the availability of funding through the PMI:

1. It will provide training/supportive supervision to health workers in the prevention and treatment of malaria in pregnancy and in treatment of uncomplicated and severe malaria;
2. It will develop and disseminate IEC messages for malaria in pregnancy and for children under 5 years of age;
3. It will develop implementation strategies for microscopy and Rapid Diagnostic Test (RDT) use and provide pre-/in service training in laboratory diagnosis and quality control for malaria;
4. It will support ACT implementation at provincial, district and health facility levels; and,
5. It will work closely with other malaria implementing partners, including sub-grants to NGOs FBO, and potential public/private partnerships.

1.1 Specific Tasks

The contractor shall undertake the following tasks:

Task 1: Preventive Activities

According to the 2003 DHS survey, 84% of pregnant women attend an antenatal clinic (ANC) at least once during their pregnancy in Mozambique. Approximately 81% of pregnant women make two or more visits, although these visits tend to take place late in pregnancy. As would be expected, ANC attendance rates were found to be lower in rural than in urban areas. Several partners have reported that ANC attendance rates increased following distribution of free ITNs in those clinics. It is new MoH policy to provide ITNs to all pregnant women receiving care at public ANCs.

Intermittent preventive treatment for pregnant women was approved as a national policy in May 2004. Because of high HIV seroprevalence rates, the NMCP recommends that women receive three doses of SP during their second and third trimesters. Implementation started in 2006 in provincial

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and district capital hospitals and NMCP and MoH Family Health Section are expanding this intervention to all 1,000 health facilities nationwide that provide ANC services this year. The NMCP and Family Health Unit staffs have collaborated in developing and implementing the policy, while the reproductive health officials have provided training on IPTp to the Provincial Coordinators for HIV/AIDS Tuberculosis and Malaria, , , staff from NGO implementing partners, and MoH maternal and child health nurses who provide ANC services that include IPTp, ITN distribution as well as prevention of mother-to-child transmission of HIV/AIDS (PMTCT).

In FY07, many of the President's Emergency Plan for AIDS Relief (PEPFAR) PMTCT partners will introduce cotrimoxazole prophylaxis for seropositive women, which will preclude the provision of SP because of an increased risk of adverse drug reactions. Close coordination with the MoH Family Health Section to develop appropriate ANC protocols and guidelines will be required, while PEPFAR and PMI implementing partners will assist in training and supervision of ANC providers to make sure that these two important interventions are delivered in a coordinated and complementary manner.

Principal Sub-Task:

a) Training/supportive supervision of health workers in prevention/ treatment of malaria in pregnancy

As the MoH plans to expand IPTp to more peripheral health facilities over the next year, a review of existing training and IEC materials related to malaria in pregnancy will be needed and the MoH will require additional support in training and supportive supervision of health workers and for disseminating health messages about malaria in pregnancy.

In collaboration with non-governmental organizations (NGOs), private voluntary organizations, (PVOs) and Faith-based Organizations (FBOs) this sub-task will provide training and supportive supervision to health care workers in IPTp and the diagnosis and management of malaria in pregnancy. Materials for such training and supervision have already been developed by WHO and others, but may need to be adapted to the local situation. It will optimize delivery of the full package of ANC services which includes PMTCT by linking PEPFAR and PMI implementing partners working in the same health facilities and technical advisors working with central level reproductive health staff to review and refine protocols and guidelines to include pregnant women who are HIV positive.

Performance indicators:

- Intermittent preventive treatment with SP in pregnant women will have been implemented in all health facilities in 11 provinces
- 85% of pregnant women who have completed a pregnancy in the last 2 years will have received 2 or more doses of SP for ITPp during that pregnancy
- 90% of households with a pregnant woman (in areas not covered by IRS) will own at least one ITN

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Task 2: Case Management

Diagnosis: Malaria diagnosis in most MoH facilities in Mozambique is based on clinical grounds. Only about 20% of all malaria diagnoses are based on microscopic examination and the quality of those diagnoses is unclear. The Instituto Nacional de Ciências da Saúde has been responsible for the training of malaria microscopists. Senior microscopists from the Instituto Nacional de Ciências da Saúde and the NMCP have made periodic supervisory visits to provincial laboratories for refresher training. The most recent refresher training conducted in November/December 2005 included two microscopists from each province. The Secção de Laboratórios of the MoH is responsible for evaluating laboratory equipment and reagent needs and for the training of staff in the use of new equipment. A plan for laboratory diagnosis, including which tests will be recommended and quality control, has been drafted and was recently approved (see annex 1).

With this newly drafted policy on the role of microscopy and rapid diagnostic tests (RDTs) in malaria diagnosis the NMCP has as its goal to introduce the use of RDTs in public health facilities in 2007 and strengthen microscopic diagnosis where it already exists. RDTs have already been introduced at health facilities in Maputo Province as part of the LSDI Project in 2003.

Treatment: Over the last four years, Mozambique has undergone two changes in national malaria treatment policy. In 2002, AQ-SP was introduced as an interim first-line treatment until ACTs could be adopted. In late 2004, the policy was changed to AS-SP, with another ACT, artemether-lumefantrine (AM-LUM) as the second-line therapy. Sulfadoxine-pyrimethamine was chosen over AQ because of the side effects of AQ and the potential for cross resistance with chloroquine. Quinine is the third-line drug and is recommended by the NMCP for the treatment of severe malaria. New MoH treatment guidelines for malaria were recently released and distributed to all provinces (see summary of guidelines attachment). Although not included in the written guidelines, the NMCP has stated that artesunate rectal suppositories can be used for the emergency treatment of severe malaria in children in settings in which intramuscular or intravenous quinine can not be administered, as recommended by the WHO. The treatment guidelines also state that AS-SP should not be used in children under six months of age but no alternative is offered (see Annex 2).

Implementation of AS-SP started in Maputo Province in late 2002 as part of the LSDI. The MoH began to scale up implementation of AS-SP in the remainder of the country beginning in early 2006, but the level of ACT roll out varies from province to province, being most advanced in Maputo, Gaza, Sofala, Zambézia, and Nampula Provinces. The Provincial Coordinators for HIV/AIDS, TB and Malaria were trained on the new policy in 2006 as part of a one-day workshop and they were then made responsible for training health workers at the district and health facility levels. At the present time, only those health facilities with a physician are using AS-SP. It is expected that all levels of health facilities (including community health posts) will be implementing ACTs by 2007. Problems with ACT implementation have also been reported, including drug stock outs, AM-LUM being used as the first-line drug, and frustration on the part of patients because of poor health worker attendance at health facilities.

The Central de Medicamentos e Artigos Medicos (CMAM), under the direction of the National Health Directorate within the MoH, has primary responsibility for supplying the national public health system with medicines and medical supplies. Currently, antimalarials are distributed through

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two mechanisms: the kit system, which is considered a “push” system, and the ‘via classica,’ which is a “pull” system.

The kit system distributes three different kits (A, B and C), each with its own pre-defined set and quantity of essential medicines. Kits are delivered directly to provinces, from which they are then sent out to the health centers, health posts and community health workers on a monthly basis. Hospitals do not receive medicine kits. All of the kits being procured this year for distribution in 2007 will contain AS-SP. Artemether-lumefantrine and quinine (tablets and ampoules) are not used at the lower levels of the health system, and therefore are not included in any of the kits.

The so-called “via classica” is the system for distributing antimalarials to warehouses and hospitals at the central, provincial, and district levels. In the “via classica,” warehouses, hospitals, and facilities submit requisitions to the distribution point above them for the medicines they will need for the next quarter.

Ensuring prompt, effective, and safe ACT treatment to 85% of patients with confirmed or suspected malaria in Mozambique will represent one of the greatest challenges for the NMCP, given the need for training of health workers and education of patients about the new treatment policy. In addition, it is likely that the current guidelines for first and second line treatment will change in the coming year. This new change would address the concerns of the potential for SP resistance to emerge, because of the recently widely implemented ITp SP regimen. Since increasing ACT coverage rates is a high priority both for the NMCP in their National Malaria Strategic Plan for 2006-2009 and the PMI, the PMI will coordinate its activities with those of the NMCP and other partners.

Principal Sub-tasks:

With the increased cost of ACTs compared with AQ-SP, accurate diagnosis will be critical to target antimalarial drug use to infected patients and reduce the unnecessary use of these drugs that occurs when patients are presumptively treated for malaria. The PMI views malaria laboratory diagnosis as a key component of good case management and will support strengthening of malaria diagnosis in MoH facilities with diagnostic laboratories. The PMI also recognizes the benefits of combining malaria laboratory training with training done by partners working on other diseases, such as tuberculosis.

a) Microscopy/RDT strategy development

Under the guidance of NMCP and in collaboration with CDC, the MoH, and other partners, this sub-task assists the NMCP to develop a national implementation strategy and plan for the use of microscopy and RDTs at different levels of the health system and in different clinical settings in the country, including decisions on which age groups should be targeted for malaria laboratory diagnosis.

b) Procurement of microscopes and refurbish central malaria reference laboratory

Under the guidance of the NMCP, procure and distribute 80 binocular microscopes, and 80 microscopy kits among 11 provincial/district hospital laboratories. Refurbish, through construction, laboratory equipment, including a multi-headed teaching microscope, and office supplies, the primary reference diagnostic training center at the Institute of Health in Maputo.

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c) Pre-/in service training in laboratory diagnosis and quality control

In collaboration with CDC, this sub-task will work with the NMCP and the Instituto Nacional de Saude (INS) to strengthen pre-service and in-service training for MoH laboratory technicians in malaria diagnosis, including both microscopy and RDTs. Close coordination will also take place with the HIV/AIDS activities.

This will include the following:

1. Development of a plan for microscopy training of MoH laboratorians, including pre-service training for incoming laboratory workers and refresher training for current technicians;
2. In collaboration with the CDC, Provision of an in-depth refresher course on malaria for senior laboratory staff at the reference diagnostic and training center. These will be the professionals responsible for training laboratory technicians at the provincial level, quality control, and other activities related to malaria diagnosis;
3. Provision of support for on-the-job training for MoH laboratory workers in malaria microscopy and the use of RDTs at the province level (all 11 provinces). This activity should be coordinated with other planned activities related to improving laboratory diagnosis of other diseases, e.g., HIV/AIDS, tuberculosis, etc.; and
4. Provide assistance to the NMCP with the Development and implementation of a plan on quality control of microscopy and RDT diagnosis, including regular supervisory visits, systematic review of a predetermined percentage of positive and negative blood smears, and simultaneous use of both tests in a small percentage of cases to check accuracy.

d) Training/supportive supervision of health workers in treatment of uncomplicated and severe malaria and malaria in pregnancy and children under 5 years of age

Under the guidance of the NMCP, and through sub-grants to NGOs/FBOs and working with the MoH/NMCP, this sub-task will support the MoH and NMCP in pre- and in-service training and supportive supervision of health workers to ensure safe and effective ACT prescribing and dispensing practices according to NMCP guidelines and in coordination with the MoH Integrated Management of Childhood Illness (IMCI) program. It will also support training on the recognition and management of severe malaria according to NMCP guidelines, which conflict with the stock of AS-SP that are now being distributed as a blister through the “via classica” and in the medicine kits. This will require additional training and attention. In addition, this sub-task will need to be closely linked with the activities of other implementing partners already supporting training related to IMCI and maternal and child health, including IPTp.

Performance indicators:

- 85% of government health facilities will have ACTs available for the treatment of uncomplicated malaria;
- 85% of children under five with suspected malaria will have received treatment with an antimalarial drug in accordance with national malaria treatment policies within 24 hours of the onset of their symptoms

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Task 3. Behavior Change and Communication (BCC) and Information and Education and Communication (IEC) for malaria with focus on pregnancy and children under 5 years of age

Both the NMCP and partners agree that BCC/IEC related to malaria advocacy, prevention, and control is in need of strengthening. The NMCP reports that public awareness about how to prevent and treat malaria is low, particularly in rural areas, in spite of the MoH's twice yearly promotion of National Malaria Awareness Days.

The MoH has taken some steps to begin addressing this problem. A draft communication strategy called, "Moving from Malaria Awareness to Behavior Change Communication" has been developed. In addition to the draft communication strategy, the MoH has included a section on "Health Promotion and Mobilization" in its interim 2006 Strategic Plan for Malaria Control. These two documents offer a starting point for developing a unified and comprehensive national plan for BCC related to malaria. The MoH also plans to work more closely with NGOs, traditional healers, community leaders, and community-based organizations to improve local residents' understanding of and ability to deal with malaria.

Principal Sub-Tasks:

a. Facilitate the development of locally appropriate/plan for dissemination of IEC messages for malaria in pregnancy

This sub-task will work through sub-grants to NGOs/FBOs to support a review of existing information on knowledge and perceptions related to malaria in pregnancy in Mozambique and, based on already existing IEC/BCC materials for malaria in pregnancy, development of locally appropriate messages to make women aware of the risk of malaria during pregnancy, conduct pre-delivery testing of malaria knowledge promote early and regular attendance at ANCs, (more than 2 visits, early first visit, etc.) and the use of IPTp beginning early in the second trimester of pregnancy, and completion of the recommended three treatment doses.

b. Provide technical assistance for IEC/BCC activities

Provide experienced BCC advisors to assist the Health Education Department (RESP) at the central MoH and the Provincial Health Educators to implement IEC/BCC activities that are culturally suitable and appropriate to increase the acceptance of and access to the key malaria interventions--ITNs, IPTp, ACTs, and IRS.

c. Expand partners capable of effectively reaching communities

Provide a mechanism to increase and expand the role of faith-based organizations (FBO), community-based organizations, local in educating, promoting and facilitating the adoption of behaviors that will result in significant decreases in malaria in urban and rural communities.

Performance Indicators:

- 30% of districts that organized IEC activities (with exception of community radio programs)
- 90% of Health facilities with MoH approved IEC material
- Greater than 60% of schools with MoH approved malaria IEC material

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Task 4: Monitoring and Evaluation (M&E)

Malaria is included in the reporting system of notifiable diseases managed by the Departamento de Epidemiologia which requires all public health facilities to report on the number of malaria cases on a weekly basis. Although cases are stratified by age group (<5 years old and ≥ 5 years old), no effort is made to distinguish clinically diagnosed cases from those that are confirmed by laboratory testing. The data are transmitted to the provincial and, subsequently, to the national level. While this program is considered to be the best functioning health information system in the country, it has limited capacity and there are concerns about the accuracy, completeness, and timeliness of the data.

The NMCP also collects information on malaria case fatality rates from a sentinel surveillance system based in provincial, general, and rural hospitals throughout the country. UNICEF has recently completed an exercise to map the geographic location and extent of malaria control interventions nationwide, but with the rapid scale-up and evolution of malaria interventions in Mozambique, information will need to be updated on a regular basis.

Strengthening monitoring and evaluation capabilities is a high priority for the NMCP and its partners. A nationwide Malaria Indicator Survey that will provide baseline information for the 2007-2009 Strategy and Plan is planned for early 2007. In late 2007, Mozambique will conduct a mortality survey in follow-up to the 2007 National Census with funding from PEPFAR and technical assistance from the U.S. Bureau of Census and the University of North Carolina MEASURE/Evaluation Project. The INCAM survey will determine the levels of HIV and malaria mortality over the previous twelve months as initially reported during the Census. A total population of approximately 844,000 residents in all 11 provinces will be covered by the INCAM survey.

Principal Sub-Tasks:

a) Assess/strengthen MoH malaria sentinel site surveillance system

In collaboration with CDC and other partners, this sub-task will assist the Departamento de Epidemiologia and the NMCP to assess and improve the quality, accuracy, completeness, and timeliness of malaria-related surveillance data (cases of malaria and anemia, severe malaria, and malaria- and anemia-related deaths) and reporting at the district, provincial, and national levels, with particular emphasis on supporting sentinel malaria surveillance sites.

b) Development and implementation of an integrated M&E plan

Following on the UNICEF mapping exercise on the status of malaria interventions throughout the country, this sub-task will work with the NMCP, the CDC, and other partners to develop and implement a single, comprehensive and integrated monitoring and evaluation plan for malaria in Mozambique that would make use of data from various sources, including:

- Large-scale, population-based household surveys (e.g., DHS, MICS, MIS);
- Routine data from sentinel sites;
- Data from occasional surveys or evaluative activities that are designed to answer a specific question (e.g., antimalarial drug efficacy testing; insecticide resistance testing); and
- Other data sources.

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It will also include supportive supervision of health workers and strengthening of the capacity of the NMCP (through either direct support or assistance) to collect and analyze data, reach conclusions, and respond in a rational and timely fashion.

c) Assist NMCP improve Information and Communication Technology (ICT) systems and infrastructure

The Contractor will assist the NMCP to assess the current ICT systems and how these meet current ICT needs for advocacy, decision-making and communications.

- Support NMCP to more effectively use available health information for M&E decision-making at all levels and to communicate within different departments in the MOH and at all levels, including provincial levels.
- Support NMCP to streamline routine operational tasks, training and reassigning human resources to focus on health sector information analysis and application.
- Support the NMCP to acquire needed ICT equipment (including computers, copier machines, and fax machines) and technical assistance to maintain these equipment and systems.
- Assist the NMCP to improve the quality and use of information collected routinely for M&E and through the health information system.
- Assist MOH to use ICT to enhance information sharing.

d) Antimalarial efficacy studies at sentinel sites

This sub-task will support antimalarial drug efficacy studies first- and second-line drugs at geographically-representative sites throughout the country in coordination with the NMCP in using standard WHO protocols for such testing.

Performance indicators:

- A functioning malaria sentinel surveillance system
- Development and implementation of a cost-effective plan for ongoing monitoring of antimalarial drug efficacy.

1.2 Capacity Building

Programs should strengthen in-country capacity and foster collaboration as in-country capacity is the foundation for long-term success. Sustainable health systems and services at the national and local level depend critically on the engagement and commitment of key stakeholders - local people, government, civil society, enterprises, NGOs and donor institutions. In addition, good cooperation and coordination among USG implementing partners and other donors is necessary.

2. REPORTING, DELIVERABLES & ADMINISTRATIVE REQUIREMENTS

The following sub-sections describe the nature and content of plans and reports required for planning, implementation and monitoring of the Task Order. Most of these deliverables are interrelated. The format of all of the different plans and reports should be compatible with NMCP and USAID plans and designed to allow analysis among the completed activities, expenditures, and results for each year of the program.

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2.1 ACTION PLANS

2.1.1 Three-Year Strategic Plan

Within the first 60 days after the arrival of the first long-term TA team member in Mozambique, the Contractor will submit a “draft” three-year strategic plan that encompasses the activities required to achieve results, the corresponding time frames, and an estimated budget required to achieve the four tasks. In contrast to the Annual Action Plans (described in 2.1.2 below), the three-year Strategic Plan will focus on the three-year chain of actions needed to achieve the targeted end results of the PMI and NMCP strategies. The Contractor will work closely with the NMCP and other stake holders in developing the final plan. This three-year Strategic Plan will be submitted in a format mutually agreed among the NMCP, the Contractor and USAID/Mozambique.

2.1.2 Annual Action Plans

Within the first 60 days after the arrival of the first long-term TA team member in Mozambique, the Contractor will submit an Annual Action Plan for Year 1, designed with input from NMCP and USAID. This Annual Action Plan, and Annual Action Plans for subsequent years, will describe the activities and interventions to be carried out and the corresponding time frames. The Annual Action Plans will include as an integral component of the Annual Capacity Building/Training Plan (described in 2.1.3 below). The Annual Action Plan will also incorporate a Financial Report. The Annual Action Plans will provide information in a format mutually agreed with the NMCP and USAID/ Mozambique.

The Contractor will develop annual action plans in collaboration with the NMCP and the PMI team. The plans are subject to first the endorsement by the NMCP and MOH before receiving approval from the USAID/Mozambique CTO for the TASC3 Task Order. The CTO, will review and approve plans to ensure that they are within the TASC3 Scope of Work and contribute to the PMI Malaria Operational Plan.

2.1.3 Annual Capacity Building/Training Plans

As part of the Annual Action Plan submissions, the Contractor will submit an Annual Capacity Building/Training Plan for all Contract-funded training activities. The plan will be based on the Annual Action Plan and consist of pre-service and in-service or more formal training designed to support achievement of MOH PES and MOP. The timing of actions will be shown in the Annual Action Plan. The separate Capacity Building/Training plan will be used to meet USAID review and reporting requirements. The plan will include a brief description of the relationship to the MOH PES and Human Resource Development Plan, types of capacity building/training proposed by category (international, national or provincial); expected cost; source of training; and proposed timing. The Annual Capacity Building/Training Plans will provide information in a format mutually agreed with the NMCP and USAID/Mozambique, and will be included in the USAID Tracking System for training in accordance with ADS.

2.1.4 Small Grants Management Plan

The Contractor will submit a final small grants management plan within 60 days after the signing of the Task Order agreement. This plan is expected to be developed in collaboration with the CTO and should describe: the grant solicitation process, grant oversight responsibility, and evaluation of grant results.

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2.2 MONITORING AND EVALUATION

2.2.1 Performance Monitoring Plan

Expected program results with illustrative indicators are provided in this document. However, during the initial program planning period and within the first 60 days after the arrival of the first long-term TA team member in Mozambique, the contractor shall work closely with the NMCP and the PMI team to select final indicators, establish and/or select baseline data and performance targets for each indicator, and finalize a Performance Monitoring Plan (PMP), based on the MOP, which monitors progress towards achieving results. The PMP will be developed in accordance with USAID guidelines. To the extent it is possible, performance-monitoring systems will be integrated into, and will enhance existing MOH management information systems.

The PMI and NMCP teams and the contractor will conduct monthly meetings to monitor the progress of work and identify and resolve constraints. There will also be bi-annual joint USAID/MOH performance reviews involving all USAID funded health partners to monitor the achievement of results based on the targets specified in the PMP and MOH expected results.

2.2.2 Six Monthly Performance Monitoring Reports

All Performance Monitoring Reporting will be in a format compatible with USAID's format of the Mission's Annual Performance Report to USAID/Washington. The report shall discuss progress against the Performance Monitoring Plan, results achieved, constraints affecting implementation and proposed solutions.

Performance monitoring reports will include program outcomes, and results based on the three-year strategic plan, annual action plans, and the indicators and targets in the MOP. As specified in these plans, the data for performance monitoring may be from a variety of sources, including: (i) the MOH HIS; (ii) facility and community level assessments; (iii) field visits; (iv) other relevant analyses and reports; and (v) the Contractor's primary monitoring and reporting system for this Task Order. Each six months the contractor shall report against appropriate indicators included in the PMP.

The Performance Monitoring Report format should contain at a minimum the following information:

- Activities and interventions implemented in last six months;
- Reported Results;
- Planned activities and interventions for next six months;
- Expected future results;
- Performance;
- Compelling individual-level success stories; and
- Documentation of better practices that can be replicated or taken to scale.

2.2.3 Monthly Performance Reports

The Monthly Performance Reports shall discuss progress against the Annual Action Plan (2.1.2), results achieved, constraints affecting implementation and proposed solutions. The report shall also address

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whether and how constraints reported in previous reports have been addressed and resolved and shall also include discussion of activities and events planned for the next month.

Monthly Performance Reports will include program activities, outcomes, and results based on the three-year strategic plan, annual action plans, and the indicators and targets in the SO8 Performance Monitoring Plan. These reports should not exceed two pages (refer to attached sample report format).

The Monthly Performance Report format should contain at a minimum the following information:

- Progress (achievements) since the last report;
- Problems described in previous report solved or still outstanding and intentions to address outstanding problems;
- New problems encountered since previous report;
- Proposed solutions to outstanding and new problems; and
- Plan for next month.

2.2.4 Final Task Order Report:

This final report will highlight major successes achieved during the Task Order period with reference to established objectives and indicators, and should also discuss any shortcomings and/or constraints encountered. The Contractor will submit a detailed final report within 60 days of completion of the Task Order which includes:

- A financial report detailing how funds were expended, by line item;
- A summary of the accomplishments against work plans, giving the final tangible results; and
- A summary of deliverables/benchmarks, addressing lessons learned during implementation and suggesting ways to resolve constraints identified.

2.2.5 Development Experience Document

Development Experience Clearinghouse: Submission of Development Experience Documents to PPC/CDIE/DI shall be done by the Contractor in accordance with AIDAR 752.7005. USAID Contractors must submit one electronic copy and one hard copy of development experience documentation to the Development Experience Clearinghouse at the following address:

USAID Development Experience Clearinghouse
8403 Colesville Rd., Suite 210
Silver Spring, MD 20910
Telephone Number: (301) 562-0641
Fax Number: (301) 588-7787
E-mail: docsubmitndec.edie.org
<http://www.dec.org>

2.3 FINANCIAL REPORTING

Financial Status Report information will be provided in a functional format to allow an examination of the cost of carrying out major action plan activities rather than simply providing conventional “budget categories” for major expenditures.

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PROPOSALS (RFTOP) THAT WILL BE ISSUED ONCE FUNDS BECOME
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15 days before the end of each calendar quarter, the contractor shall submit a detailed quarterly financial report with separate line items illustrating all vouchered and accrued monthly expenses. The report should contain at a minimum the following information:

- Total life-of contract budget;
- Total funds awarded to date;
- Total funds expended by the Applicant to date, including direct and indirect administrative costs;
- Total expended (actual plus estimated accrued)
- Estimated expenditures for remainder of year; and

2..4 MISCELLANEOUS REPORTING REQUIREMENTS

Implementation problems: The Contractor shall immediately report to the USAID Contracting Officer and the Cognizant Technical Officer any implementation problems affecting work quality, price or delivery schedules.

Document specifications: All plans, reports and other documentation prepared under this Task Order shall be provided in English as a finished document both in hard copy and electronically. Documents will be prepared in Microsoft Word, Microsoft Excel and/or Microsoft PowerPoint. All project planning is encouraged to be done using Microsoft Project Planning.

Report of USAID-funded property: In accordance with USAID acquisition regulations, the Contractor is required to submit Annual Inventory Reports of all non-expendable, USAID-funded property in the Contractor's custody (based on the calendar year). Copies will be submitted to USAID/Mozambique.

2.5 ADMINISTRATION

The contractor shall fulfill the following administrative requirements:

- Equip and staff an office within as close a proximity as possible to the NMCP offices in Maputo. The office will house the contractor's entire staff, including short-term consultants;
- Recruit and field local and international consultants and experts as needed. Where feasible, the contractor shall make maximum use of available local expertise for short-term assignments. In fielding all short-term experts but particularly with expatriate short-term expertise, the contractor shall ensure continuity of technical assistance by utilizing a limited pool of specialists who make repeated visits to work on continuing activities;
- Organize in-country logistics and travel for meetings, site visits and other activities outlined in the approved program implementation plan;
- Ensure compliance with all applicable USAID rules and regulations. Funds for this three-year program come from the Presidential Malaria Initiative (PMI) earmark. The contractor shall manage funds ensuring strict adherence to all USAID funding guidelines and regulations.

Program support provided through the Contractor is intended to support training, technical assistance, assessment, and follow-up rather than to replace NMCP and other donor support for operating costs.

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3. CONTRACTOR PERSONNEL

3.1 KEY PERSONNEL

For Key Personnel offerors should submit a summary of qualifications and demonstrated experience as well as a letter of commitment from proposed candidates. Below is an *illustrative* breakdown of possible positions, depending on the individual skills mix of key personnel proposed:

Chief of Party

The Chief of Party (COP) will be responsible for overall planning and management of activities under this Task Order. The COP is primarily responsible for facilitating senior level policy and technical dialogue with the NMCP, MOH other GRM Ministries and International Partners. The COP will assist the NMCP and MOH in working: 1) across operational units at the central level through the implementation of new policy, planning and management processes; 2) between the central level and the Provincial/District levels to enhance information flows and facilitate implementation of programs; 3) with other Ministries to facilitate implementation of NMCP and MOH priorities; and 4) with international partners to insure coordination with NMCP.

The COP will also assist USAID/Mozambique with effective use and coordination of PMI resources.

Additional Terms of Reference:

- Graduate level training in public health management, public administration, health finance, health economics or related discipline.
- Excellent communications skills, both oral and written in English and preferably in Portuguese. For candidates not fluent in Portuguese, please provide information on other language skills and a plan for Portuguese language training.
- Demonstrated success at providing technical assistance to a developing country Ministry of Health. (Please provide references of Ministry of Health counterparts.) Preference in descending order for experience in Mozambique, southern Africa, low-income country, other developing country.
- Recent prior experience overseeing a long-term health technical assistance program of similar nature and scope, including negotiating work plans, interfacing with donors, Ministry, other development partners; developing terms of reference, identifying technical assistance sources, and ensuring high quality.
- Demonstrated excellent interpersonal and cross-cultural skills.
- Skills and experience anticipated in some combination of the following: negotiation, advocacy, health policy development and strategic planning, information management, health human resources, decentralization of health systems and local health planning, managing community participation, health care quality improvement, and technical areas of maternal, reproductive and child health, nutrition, malaria.

Senior Technical Officer/s

The work of the COP will be facilitated by senior level position technical advisor/s.

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A Senior Malaria Technical Officer (SMTO) will focus on the content of advocacy messages and the evidence base for policies and strategies developed through dialogue with the NMCP, MOH, other GRM Ministries and International Partners. The SMTO will also provide guidance and oversight to the technical members of the local team and short-term technical consultants. The SMTO provides assistance to the MOH in translating national policy into practical guidance to support implementation of the Provincial and District levels and, when required, in developing technical proposals for funding health sector activity. The SMTO also plays a role in ensuring the technical quality of PMI activities implemented through sub-grants.

The COP may require a Senior Advisor for BCC/IEC and/or M&E as the BCC/IEC and M&E components of this Task Order are significant. This/these Senior Advisor/s will focus on providing technical assistance at the central and Provincial/District level for activities that promote the increased awareness of malaria, and the use and acceptance of malaria-related services, working with partners, such as FBOs, to effectively reach communities. The/se Senior Advisors will also focus on improving the quality of malaria-related surveillance data and reporting at the district, provincial, and national levels, as the malaria interventions in Mozambique will rapidly scale-up and evolve. These activities include the strengthening of the capacity of the NMCP (through either direct support or assistance) to collect and analyze data, reach conclusions, and respond in a rational and timely fashion

Additional Terms of Reference:

- Graduate training in public health or related discipline, preferably at the doctoral level (MD with MPH, Ph.D. or equivalent in qualifications or experience).
- Excellent communications skills, both oral and written in English and preferably Portuguese. For candidates not fluent in Portuguese, please provide information on other language skills and a plan for Portuguese language training.
- Minimum of 10 years experience implementing and evaluating large-scale public health programs in Africa..
- An excellent understanding of the malaria-related issues facing pregnant women and young children in Mozambique.
- Demonstrated capacity to advise the Chief of Party on technical issues related to malaria-related health policies and strategies, interventions, and innovations.
- Demonstrated capacity to compile, evaluate and maintain the malaria-related evidence base to support advocacy, policy dialogue and planning with the Central MOH, Provincial and District Health Teams and implementing partners
- Demonstrated BCC/IEC and/or M&E training and capacity.
- Demonstrated experience in providing oversight and guidance to technical staff and short term consultants concerning the focus and timely completion of their work.
- Provides assistance to the MOH in translating policy into implementation guidelines for use at the Provincial and District levels.
- On technical issues, serves as the primary point of contact for PMI cooperating agencies working at the Provincial and District levels.
- Responsible for collecting and maintaining information required for quarterly and annual reporting to USAID.

3.2 STAFFING PLAN

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The staffing plan for a Maputo-based team will be finalized following award of the Task Order and consultations with USAID/Mozambique and the MOH. The team should be recruited locally to the extent possible to optimize use of Mozambican resources.

For the purposes of this application, offerors should propose a draft staffing plan for the Maputo-based team that takes into consideration the purpose and scope of the Task Order, the roles and skills of named key staff and the complementary array of local and short-term assistance that will be available.

Local technical assistance

The Maputo based team should be small but have the necessary managerial and technical skills required 'on site'. The draft staffing plan should include a description of the key roles and responsibilities as well as the minimum qualifications and experience required for each proposed position. It is not necessary to identify named candidates, although offerors are encouraged to describe their proposed approach to recruitment of local staff.

Short-term technical assistance

USAID/Mozambique recognizes the need for short-term technical assistant to complement the skills and enhance the work of Maputo-based staff.

It is the preference of USAID/Mozambique that, to the extent possible, offerors utilize short-term technical assistance resources available locally (in Mozambique and the Africa Region) and actively promote South-South technical assistance to foster South-South exchange and minimize travel costs.

Continuity is an important aspect of short-term technical assistance and offerors are encouraged to identify consultants who will be able make repeated visits to Mozambique and develop highly functional working relationships with Maputo-based staff and country counterparts. To this end, offerors are encouraged to: 1) identify a focal point and alternate who are committed to providing ongoing assistance. The qualifications, skills, experience and minimum availability of each focal point and alternate should be provided; and 2) provide information on additional technical assistance resources that can be mobilized by the offeror.

4. INSTRUCTIONS TO OFFERORS

Offerors should submit a technical proposal that includes, at a minimum, the following: (a) Cover Page; (b) Executive Summary; (c) Narrative; (d) Annexes, consisting of at a minimum information on Offeror's Team, Management Plan, Institutional Capacity and a proposed Monitoring and Evaluation Plan. Page limitations are specified below for each section; applications must be on 8-1/2 by 11 inch (210mm by 297mm paper) or A4 paper, single spaced, 10 pitch type or larger, and have at least one inch margins on the top, bottom and both sides.

4.1 TECHNICAL PROPOSAL:

The technical approach must set forth the conceptual approach, methodology and results to be achieved by the Offeror's program. The rationale for the appropriateness of the suggested approach should be explicit.

- Cover Page:

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A single page with the names of the organizations/institutions involved in the proposed application. Proposed subcontract and/or sub-grants (hereafter referred to as the subs) should be listed separately, including a brief narrative describing the unique capacities/skills being brought to the program by each sub. In addition, the Cover Page should include information about a contact person for the prime Offeror, including this individual's name (both typed and his/her signature), title or position with the organization/institution, address and telephone and fax numbers. Also state whether the contact person is the person with authority to contract for the Offeror, and if not, that person should also be listed.

- Executive Summary:

The Executive Summary shall not exceed two pages and should summarize the key elements of the Offeror's strategy, approach, expected results, and implementation plan. The Executive Summary must be concise and accurate.

- Narrative:

In 20 pages or less please describe your proposed strategy and approach. The narrative should be brief, concise and provide a clear description of what the Offeror proposes to do, why, and with whom and how the Offeror will effectively assess the achievement of program objectives. The Offeror should be able to demonstrate, with sufficient evidence, the merits of the proposed approach and its wider application based upon lessons learned and past experiences.

- Management:

As part of the narrative, offerors should provide a clear description of how the task order will be managed, including the approach to addressing problems and challenges. Proposals should outline which subcontractors will conduct the various tasks listed earlier, if applicable. Offerors should propose a management plan that demonstrates the Offeror's understanding of management barriers that could occur during project implementation on both a global and country level, and how the Offeror plans to overcome these barriers. The plan should also demonstrate how the Offeror will use existing in-country resources for rapid start up. This plan should also address how the Project Director will liaise with the CTO, in-country staff, and reporting and management among other partners and subcontractors, if applicable. Offerors are encouraged to include an organizational chart in an Annex to the technical proposal.

- Institutional Capability:

The quality of an Offerors' institutional capability to carry out the tasks is a factor in consideration of award. As part of the narrative, the Offeror should furnish evidence that they, along with their proposed subs, have the ability to plan, implement and monitor similar programs effectively.

- Offeror's Team (Resumes, Letters of Commitment, and References):

Offerors should provide summary job descriptions and qualifications of all key professional staff, local and expatriate, to be funded under the contract. Resumes/CVs for these staff, not to exceed 3 pages, should be provided, including the developing-country experience of expatriate staff and recent references from persons familiar with the individual's work. Proposals should include copies of letters from all key professional staff to the effect that they will accept the position in question for the entire period of the contract, should the Offeror receive an award.

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- Offeror's Past Performance Data: The quality of an Offeror's past performance on similar programs is a factor in consideration of award. The Offeror should furnish information on all U.S. Government contracts, grants, or cooperative agreements involving similar or related programs over the past three years in which your organization has been involved. The information should include (at a minimum) the following for each program:
 - Name and address of funding organization;
 - Name, address and phone number, if possible, of the individual from the funding agency's number assigned to the contract, grant or cooperative agreement;
 - A brief description of the program;
 - Start and end dates, or projected end date of the Offeror's involvement with the program; and
 - Provide independently verifiable evidence on past performance.

4.2 COST PROPOSAL:

Offerors should review table 2 in the Malaria Operational Plan for estimated costs related to each task and sub-task.

Budget Format: A budget with narrative providing detailed justification of costs anticipated under this proposed task order in the following format:

- a) Summary Cost Breakdown - For each line item proposed, please provide a breakdown, by element, of the respective anticipated costs of performing under this task order. The elements include: salaries, fringe, consultant fees, travel/transportation/per diem, other direct costs, equipment, subcontracts, grants, indirect costs (overhead, G&A, etc., if applicable), and fee.
- b) Detailed level of effort and labor cost estimates must be submitted in accordance with the Statement of Work. Please provide a separate line item for each proposed individual and identify each by name, labor category, daily rate, and the level of effort for that individual. Please provide a salary history for the prior three years, for "key" individuals and professional staff.
- c) Detailed level of effort and cost estimates for consultants who will perform under the task order. Additionally, please provide ceiling rates for consultant positions for which an individual is not specifically named according to the following position classification: US Senior Level, US Junior Level, CCN Senior Level, CCN Junior Level, TCN Senior Level, and TCN Junior Level.
- d) Indirect Costs: Provide a breakdown for all anticipated costs for this line item (i.e., the amount, type, and unit cost) in accordance with the NICRA.
- e) Fixed Fee is subject to the maximum specified in the IQC.
- f) Total Estimated Cost plus Fixed Fee.

4.3 METHOD OF AWARD

USAID may, without discussion or negotiations, award a task order resulting from this Request for Task Order Proposal (RFTOP) to the responsible contractor whose proposal conforms to the Statement of Work (SOW) and offers the best value. Therefore, the initial proposal should contain the contractor's best terms

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from a cost and technical standpoint. USAID may reject any or all proposals, and waive informalities and minor irregularities in proposals received. The technical proposal evaluation criteria are in descending order of importance.

Although technical evaluation factors are significantly more important than cost factors, the closer the technical evaluations of the various proposals are to one another, the more important cost considerations become. The Contracting Officer may determine what highly ranked proposal based on the technical evaluation factors would mean in terms of performance and what it would cost the Government to take advantage of it in determining the best overall value to the Government.

4.4 EVALUATION CRITERIA

TECHNICAL APPROACH	30 points
a) Is complete and responsive to the USAID/Mozambique health program objectives, level of focus and efforts, and objectives under the PMI, including level of focus, efforts and monitoring and evaluation of results.	10 points
b) Demonstrates an understanding of health sector issues in Mozambique.	5 points
c) Integrates sustainable capacity building as a core principle in each of the actions proposed.	5 points
d) Offers a realistic proposal to strengthen and expand priority interventions, laid out in the technical approach and demonstrates strong linkages with in-country partners such as the Global Fund for Aids, Tuberculosis and Malaria .	10 points
PERSONNEL CAPACITY AND EXPERIENCE	45 points
a) Appropriateness and rationale of the proposed Personnel Structure (long- and short-term) to the proposed technical approach.	5 points
b) Expertise of Key Personnel in a range of comprehensive services required to improve the efficient and transparent management of scarce health resources, especially strengthening critical systems within the MOH for planning of health services and monitoring program performance.	30 points
c) Capacity to meet short-term technical assistance needs associated with the Task Order and using resources available locally.	5 points
d) Capacity to recruit local technical assistance and to foster South-South exchanges	5 points
INSTITUTIONAL CAPACITY AND PAST PERFORMANCE	25 points
a) Past performance on and demonstrated capability to plan, implement and monitor similar programs;	5 points
b) Capability and past performance in starting program activities rapidly;	5 points
c) Capability to support personnel and field operations;	5 points
d) Past performance in meeting USAID reporting and accountability requirements; and	5 points
e) Success in forming alliances with other organizations and/or donors.	5 points

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PROPOSALS (RFTOP) THAT WILL BE ISSUED ONCE FUNDS BECOME
AVAILABLE**

4.5 PROPOSAL DUE DATE

Proposals for this Task Proposal Request (TPR) must be submitted electronically no later than XX to the following email addresses:

mteixeira@usaid.gov

The Cognizant Technical Officer (CTO) for this task order under TASC3 Global Health is:
Will be determined at time of award.

5. PERIOD OF PERFORMANCE

Subject to the availability of funding through the Presidential Malaria Initiative, the period of performance is from the effective date of the Task Order Agreement until three years after award. Performance will be reviewed on an annual basis.

Based on the availability of funding, USAID may amend the Task Order to increase the total ceiling price to provide additional support to these program areas without further competition. In the case of additional funding of this Task Order, the Contractor shall be prepared to submit revised action plans and budgets to reflect the change in the actual ceiling price.

6. APPLICABLE DOCUMENTS

Applications must be consistent with Mozambique's 3 Year PMI Strategy and MOP and can be located at the following selected list of background materials which can be accessed at the following website:

<http://www.usaid.gov/mz/>

1. Presidential Malaria Initiative
2. PMI Malaria Operational Plan, Mozambique, 2006
3. MOH Strategic Plan for Malaria Control in Mozambique (July 2006-2009)
4. MOH Strategic Plan for the Health Sector (PES) 2001 – 2005 – (2010)

7. LIST OF KEY STAKEHOLDERS AND PARTNERS

Ministry of Health

Ivone Rungo, Director
National Malaria Control Program
Av. Eduardo Mondlane no. 287
Maputo
Telephone: +258 823 149 180
Email: ierungo@yahoo.com.br

JSI/Deliver (Drug Logistics)

Marilyn Noguera
JSI Country Director
Supply Chain Management System (SCMS) Project

**IN ACCORDANCE WITH TASC 3 PROCEDURES AND DUE TO TIME
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PROPOSALS (RFTOP) THAT WILL BE ISSUED ONCE FUNDS BECOME
AVAILABLE**

DELIVER PROJECT

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Email: mnoguera@pfscm.org.mz

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Malaria Consortium

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PSI

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PROPOSALS (RFTOP) THAT WILL BE ISSUED ONCE FUNDS BECOME
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Sample report formats

TASC3: MONTHLY PERFORMANCE REPORT

Contractor:	
Contract Number:	Reporting Period:
From:	To:

SECTION I. CONTRACTOR'S REPORT
1. Progress: <i>achievements since the last report.</i>
2. Previous Problems: <i>problems described in previous reports solved or still outstanding and intentions to address outstanding problems.</i>
3. New Problems: <i>problems encountered during this reporting period.</i>
4. Proposed Solutions: <i>to outstanding (previous) and new problems.</i>
5. Plan for next month: <i>describe briefly each of the major activities in process during the next period as found in the Annual Action Plan and/or Task Order.</i>

Note: *Not to exceed two (2) pages*

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TASC3: SIX-MONTHLY PERFORMANCE MONITORING REPORT

Contractor:	
Contract Number:	Reporting Period: From: To:

SECTION I. CONTRACTOR'S REPORT

1. Activities and Interventions: *summarize activities and interventions carried out in the last six months which were previously reported as "planned activities"*

2. Reported Results: *summarize the tangible results.*

3. Planned Activities and Interventions: *list future activities and interventions planned to be implemented within the next six months.*

4. Expected Future Results: *summarize the tangible results expected at conclusion of next 6 month period and whether this expectation is still reasonable.*

5. Performance: *for each of the activities described in number 1 and 4 above, state whether on-target or not, and comment, particularly in terms of meeting benchmarks, or other requirements established for the period and explain reasons why benchmarks or requirements were not met, as appropriate.*

6. Compelling individual-level success stories: *short paragraph (optional).*

7. Documentation of better practices that can be replicated or taken to scale: *activities that have worked well in USAID/Mozambique's geographic focus area that can be replicated in other provinces..*

Note: *Not to exceed ten (10) pages.*

SECTION II. CTO'S COMMENTS

The Cognizant Technical Officer (CTO), whether in USAID/Washington or in the field, will complete Section II and pass his/her comments on to the Contracting Officer for possible further comment. The CTO will obtain input from counterparts or others, as appropriate, prior to completing this section.

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PROPOSALS (RFTOP) THAT WILL BE ISSUED ONCE FUNDS BECOME
AVAILABLE**

<p><i>1) Comment on Contractor's technical performance (quality of technical assistance, professional services, etc.) and provide examples, if appropriate.</i></p> <p><i>2) Comment on Contractor's administrative performance (timeliness in meeting schedules and/or delivering materials/products) during the quarter and give examples, if appropriate.</i></p> <p><i>3) Comment on Contractor's management (cost-effectiveness, quality of communication with staff and with USAID) for the quarter and provide examples as appropriate.</i></p> <p><i>4) React to Contractor's assessment of performance regarding any of the activities/Benchmarks described in section IA. above.</i></p> <p><i>5) Note areas for potential Contractor improvement regarding achievement of Benchmarks and Tangible Results or any of the items covered</i></p>	
CTO/OFFICE SYMBOL:	DATE:

SECTION III - CONTRACTING OFFICE'S COMMENT (OPTIONAL)	
<p><i>- The Contracting Officer may, if he or she wishes, add comments on any areas of concern in regard to Sections I and II above or identify actions to support, correct, or improve Contractor's performance.</i></p> <p><i>- The CTO will provide timely feedback to the Contractor relative to Section II and Section III (optional comments)</i></p>	
CO/OFFICE SYMBOL:	DATE:

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**Annex 1
Rapid Diagnostic Test Guidelines**

A- CRITÉRIOS DE USO DOS TESTES DE DIAGNÓSTICO RÁPIDO (TDRs) DA MALÁRIA EM ÁREAS DE ALTA TRANSMISSÃO

1- Unidades Sanitárias com laboratório de microscopia a funcionar 24 horas por dia

- Em crianças <5 anos seguir a estratégia AIDI (não se recomenda a realização de teste de laboratório)
- Microscopia como método de eleição para crianças >5 anos e adultos
- Usar TDR nas seguintes situações
 - Suspeita de malária grave (todas as idades). O TDR deve ser usado para permitir a avaliação do paciente e início da terapia apropriada o mais rápido possível. Recomenda-se a realização simultânea da lâmina para microscopia que permitirá o controlo da parasitemia.

2- Unidades Sanitárias com laboratório de microscopia a funcionar durante a horas normais de serviço (7:30 a 15:30)

Durante o período de funcionamento do laboratório (7:30-15:30)

- Para crianças <5 anos seguir a estratégia AIDI (não se recomenda a realização de teste de laboratório)
- Microscopia como método de eleição para crianças >5 anos e adultos durante as horas de funcionamento do laboratório (Mesmo critério acima)
- Usar TDR nas seguintes situações
 - Suspeita de malária grave (todas as idades). O TDR deve ser usado para permitir a rápida avaliação do paciente e início da terapia apropriada o mais rápido possível. Recomenda-se a realização simultânea da lâmina para microscopia que permitirá o controlo da parasitemia. (Mesmo critério acima)

Durante o período em que o laboratório não esteja a funcionar (15:30-7:30)

- Crianças <5 anos
 - Tratar segundo a estratégia do AIDI (não se recomenda a realização de teste de laboratório)
- Crianças >5 anos e adultos
 - Usar TDR e tratar de acordo com o resultado
- Suspeita de malária grave (todas as idades). O TDR deve ser usado para permitir a rápida avaliação do paciente e início da terapia apropriada o mais rápido possível. Recomenda-se a realização da lâmina para microscopia logo que o laboratório volte a funcionar, o que permitirá o seguimento da parasitemia.

3- Unidades Sanitárias sem laboratório de microscopia a funcionar.

- Crianças <5 anos
 - Tratar segundo a estratégia do AIDI (não se recomenda a realização de teste de laboratório)
- Crianças >5 anos e adultos
 - Usar TDR e tratar de acordo com resultado
- Suspeita de malária grave (todas as idades). Deve-se avaliar o paciente, fazer o tratamento pré referência e transferir à unidade sanitária de referência.

**IN ACCORDANCE WITH TASC 3 PROCEDURES AND DUE TO TIME
CONSTRAINTS, THIS SCOPE OF WORK PROVIDES ADVANCE NOTICE TO
ALL CONTRACTORS OF A PENDING REQUEST FOR TASK ORDER
PROPOSALS (RFTOP) THAT WILL BE ISSUED ONCE FUNDS BECOME
AVAILABLE**

**B- CRITÉRIOS DE USO DOS TESTES DE DIAGNÓSTICO RÁPIDO (TDRs) DA MALÁRIA EM
ÁREAS DE BAIXA À MODERADA TRANSMISSÃO (ex: área da Iniciativa do LSDI)**

1- Unidades sanitárias com laboratório de microscopia a funcionar 24 horas por dia

- Microscopia como método de eleição para todas as idades
- Usar TDR nas seguintes situações
 - Suspeita de malária grave (para todas as idades). O TDR deve ser usado para permitir a avaliação do paciente e início da terapia apropriada o mais rápido possível. Recomenda-se a realização simultânea da lâmina para microscopia que permitirá o controlo da parasitêmia.

2- Unidades sanitárias com laboratório de microscopia a funcionar durante a horas normais de expediente (7:30 a 15:30)

Durante o período de funcionamento do laboratório (7:30-15:30)

- Microscopia como método de eleição para todas as idades durante as horas de funcionamento do laboratório
- Usar TDR nas seguintes situações
 - Suspeita de malária grave (todas as idades). O TDR deve ser usado para permitir a rápida avaliação do paciente e início da terapia apropriada o mais rápido possível. Recomenda-se a realização simultânea da lâmina para microscopia que permitirá o controlo da parasitêmia.

Durante o período em que o laboratório não esteja a funcionar (15:30-7:30)

- Usar TDR para todas as idades e tratar de acordo com o resultado
 - Suspeita de malária grave (todas as idades). O TDR deve ser usado para permitir a rápida avaliação do paciente e início da terapia apropriada o mais rápido possível. Recomenda-se a realização da lâmina para microscopia logo que o laboratório volte a funcionar, o que permitirá o seguimento da parasitêmia.

3- Unidades sanitárias sem laboratório de microscopia a funcionar.

- Usar TDR para todas as idades e tratar de acordo com resultado
 - Suspeita de malária grave (todas as idades). Deve-se avaliar o paciente, fazer o tratamento pré referência e transferir à unidade sanitária de referência

Notas:

- Nas áreas de alta transmissão de malária, a estratégia de AIDI deverá ser respeitada nas unidades sanitárias onde está sendo implementada.
- Na adopção do uso rotineiro dos TDRs há necessidade de se criarem condições mínimas de conservação destes materiais (temperatura, humidade e outras que podem influenciar os resultados).
- Não é recomendado o uso de TDR, especialmente os testes do tipo HRPII, nos casos de suspeita de falha terapêutica. Nestes casos, os pacientes devem ser enviados para unidade sanitária com capacidade para realizar microscopia.
- Não é recomendado o uso de testes laboratoriais, quer TDR quer microscopia, em pacientes que apresentaram remissão dos sintomas (sem sintomatologia) após o tratamento (controlo).